

UAB Student Health & Wellness Immunization Form

Non-Clinical International Students

NAME: _____ DATE OF BIRTH: (mm/dd/yyyy): _____

ADDRESS: _____ PHONE: _____

PROGRAM OF STUDY: _____ BLAZERID: _____@UAB.EDU

IMMUNIZATION HISTORY MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER

***Copies of your original immunization records are acceptable in place of this form, but MUST BE IN ENGLISH. Please submit completed form or immunization records directly to your UAB SH&W Patient Portal.**

1. **MMR-** Measles, Mumps, and Rubella: All students must satisfy this requirement, either by two vaccine doses against each of the three diseases or laboratory evidence of immunity to all three diseases.

EITHER

Two doses of MMR vaccine:

Date: ____/____/____

Date: ____/____/____

OR

Two doses of each vaccine component:

Measles

Date: ____/____/____ Date: ____/____/____

Mumps

Date: ____/____/____ Date: ____/____/____

Rubella

Date: ____/____/____ Date: ____/____/____

OR

Laboratory evidence of immunity to all three diseases:

Measles

Date: ____/____/____ Result: _____

Mumps

Date: ____/____/____ Result: _____

Rubella

Date: ____/____/____ Result: _____

*If any laboratory titers are non-immune, 2 repeat vaccines are required. Date: ____/____/____ Date: ____/____/____

2. **Tdap-** Tetanus, Diphtheria, Acellular Pertussis: All students must have had one dose of the adult Tdap given 2006 or later. If the last adult Tdap is greater than 10 years old, a Td booster is required.

Tdap Date: ____/____/____

Td Date: ____/____/____

3. **Varicella** (chickenpox or shingles): All students must have documented history of Varicella, a positive Varicella antibody titer, or two doses of Varicella vaccines given at least 28 days apart.

EITHER

History of Varicella (chickenpox or shingles): Yes: ____ No: ____

Date: ____/____/____

OR

Varicella antibody titer Positive: ____ Negative: ____

Date: ____/____/____

OR

Varicella vaccination Dose 1: ____/____/____ Dose 2: ____/____/____

*If Varicella antibody titer is negative or equivocal, two repeat vaccinations are required.

Varicella vaccination Dose 1: ____/____/____ Dose 2: ____/____/____

4. **Meningococcal:** All students 21 and younger are required to show documentation of a meningitis vaccine given on/after their 16th birthday. Students age 22 and older are exempt.

Date: ____/____/____

5. **Tuberculosis:** All students must meet UAB's Tuberculosis screening requirement. If no history of positive Tb skin test, two separate skin tests or one IGRA blood test are required upon matriculation. Skin tests must be placed at least one week apart.
***ALL TB TESTING (skin, blood, CXR) MUST BE PERFORMED IN THE U.S.**

EITHER

a. Tuberculin Skin Test (PPD) within 3 months prior to matriculation:

Date Placed: ____/____/____ Date Read: ____/____/____ Result (mm): _____ Positive: ____ Negative: ____

b. If first Tuberculin Skin Test (PPD) negative, second skin test is required. Must be placed at least 1 week after the first test and within 3 months prior to matriculation:

Date Placed: ____/____/____ Date Read: ____/____/____ Result (mm): _____ Positive: ____ Negative: ____

OR

a. IGRA (Tspot or Quantiferon TB Gold) blood test and UAB TB Questionnaire within 3 months prior to matriculation:

Date: ____/____/____ Positive: ____ Negative: ____

b. UAB TB Questionnaire

*If positive skin test or IGRA result, Chest X-Ray within 3 months prior to matriculation and UAB TB Questionnaire required.

a. Chest X-Ray Date: ____/____/____ Normal: ____ Abnormal: ____ (*Please attach results)

b. UAB High Risk TB Questionnaire

c. Have you been treated with anti-tubercular drugs? Yes: ____ No: ____

If yes, type of treatment: _____ Length of Treatment: _____ *Please attach supporting documentation.

Verification of the above Student Immunization Record and Tuberculosis Screening by Health Care Provider:

Verified by: _____ Title: _____

Address: _____

Phone: _____

Signature: _____ Date: ____/____/____